

**Applicant Must Complete**

CON Number
Facility Number
Date Submitted

**AMENDMENT REQUEST for  
CERTIFICATE OF NEED**

**Michigan Department of Health & Human Services**

**CERTIFICATE OF NEED**  
South Grand Building  
333 S. Grand Avenue, 4<sup>th</sup> Floor  
Lansing, Michigan 48933

Phone: (517) 241-3344 – Fax: (517) 241-2962

**CON OFFICE ONLY**

Amendment Fee
Amount:
Received:

**AUTHORITY:** PA 368 of 1978, as amended

**COMPLETION:** Is **Voluntary**, but is required to obtain a Certificate of Need. If NOT completed, a Certificate of Need will NOT be issued.

The Department of Health & Human Services is an equal opportunity employer, services and programs provider.

**SECTION 1 - Facility Information**

Current/Proposed Facility Name			Area Code and Telephone Number	Extension
Facility Street Address			County	
City	State	ZIP Code	Applicant's Federal ID	

**SECTION 2 - Applicant Organization****SECTION 3 - Agent Information**

Legal Name of Applicant Organization (Include assumed name applicable to this project)			Authorized Agent Name		
			Authorized Agent Organization		
Area Code, Telephone No. & Ext.		FAX No. (Area Code and No.)	Area Code, Telephone No. & Ext.		FAX No. (Area Code and No.)
Street Address			Street Address		
City	State	ZIP Code	City	State	ZIP Code
Email (administrator):			Email:		

**SECTION 4 - Justification for Amendment Request:** *(Attach additional sheets as necessary)*

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**SECTION 5 – Amended Project Description:** *(Attach additional sheets as necessary)*

*Note:* Use “Project Description” in original CON approval letter or last approved Amendment letter, which ever is most current. Amended Project Description should reflect changes requested in proposed amendment.

**SECTION 6 – Projected Completion Date**

Projected Completion Date in Application or last approved Amendment	New Projected Completion Date

**SECTION 7 – Project Costs**

Are project costs changing as a result of this amendment? <input type="checkbox"/> NO <input type="checkbox"/> YES		Provide changes in format below using most recent CON approval letter including all project costs.	
Line Item Description	Approved	Amended	+ / - Difference
1. New Construction - Clinical (     sq. ft.)	\$	\$	\$
2. New Construction – Non Clinical (     sq. ft.)	\$	\$	\$
3. Renovation and Remodeling - Clinical (     sq. ft.)	\$	\$	\$
4. Renovation and Remodeling – Non Clinical (     sq. ft.)	\$	\$	\$
5. Architect/Engineering Fees	\$	\$	\$
6. Contingencies	\$	\$	\$
7. Feasibility Study/Surveys	\$	\$	\$
8. Site Preparation	\$	\$	\$
9. Fixed Medical Equipment	\$	\$	\$
10. Fixed Non-Medical Equipment	\$	\$	\$
11. Covered Clinical Equip (PET, MRI, etc.) – Lease term (if applicable)	\$	\$	\$
12. Movable Equipment (Medical and Non-Medical)	\$	\$	\$
13. Fees (Consulting, Legal, Banking, etc.)	\$	\$	\$
14. Space Lease Cost – Term:	\$	\$	\$
15. Land Purchase	\$	\$	\$
16. Building Purchase	\$	\$	\$
17. Interest During Construction	\$	\$	\$
18. Other (explain):	\$	\$	\$
19. Other (explain):	\$	\$	\$
20. Other (explain):	\$	\$	\$
<b>TOTALS</b>	\$	\$	\$

**SECTION 8 – Sources of Funds**

Are sources of funds changing as a result of this amendment? <input type="checkbox"/> NO <input type="checkbox"/> YES		Provide changes in format below using most recent CON approval letter including all sources of funds.	
Line Item Description	Approved	Amended	+ / - Difference
1. Unrestricted Cash	\$	\$	\$
2. Designated Funds	\$	\$	\$
3. Restricted Funds	\$	\$	\$
4. Mortgages/Loans (FHA, HUD, etc.)	\$	\$	\$
5. Bond Issue	\$	\$	\$
6. Other Funds (i.e., grants, etc.)	\$	\$	\$
7. Capital/Operating Lease	\$	\$	\$
8. Gifts, Bequests, Donations, and Pledges	\$	\$	\$
9. Interest Income During Construction	\$	\$	\$
10. Other (explain):	\$	\$	\$
11. Other (explain):	\$	\$	\$

TOTALS	\$	\$	\$
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**COST PER SQUARE FOOT CALCULATIONS:**

New Construction: (\$ / sq. ft. = \$ per sq. ft.)

Renovation & Remodeling: (\$ / sq. ft. = \$ per sq. ft.)

Note: Please combine Clinical & Non-Clinical Costs and areas in calculation.

## **SECTION 9 – Document Request:**

An Amendment request shall not be considered submitted to the Department until the following documents are received, as applicable:

- A copy of audited financial statements if Project Costs or Sources of Funds have changed from the approved project. If audited financial statements are not available, provide unaudited current financial statements including a balance sheet, income statement, statement of cash flows and any notes to accompany the financial statements. New entities must provide a current balance sheet, a projected income statement for the first year of operations, a projected statement of cash flows for the first year of operations, and any notes to accompany the financial statements.
- Revised site and floor plans if changed from the approved project.
- New signed and dated vendor quotes if changed from the approved covered clinical equipment.

## **SECTION 10 – Notification:**

The new Certificate of Need (CON) fee bill (Public Act 137) was signed by the Governor on October 15, 2013, and is effective.

MCL 2016(3)(d): The department shall charge a fee of \$500 to review any letter of intent requesting or resulting in a waiver from Certificate of Need review and any amendment request to an approved Certificate of Need.

**Amendment fee (\$500) must be submitted with this request per MCL 2016(3)(d). Amendment request will not be deemed received until appropriate fee has been received. The amendment will be processed, as required by the Administrative rules, once the amendment fee is received by the Department.**